STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING _____ B. WING _____	C 04/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	**45 BEACHWAY DR INDIANAPOLIS, IN 46224**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00144640, IN00144651, IN00145599, and IN00145852.

Complaint IN00144640 Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00144651 Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00145599 Unsubstantiated due to lack of evidence.

Complaint IN00145852 Substantiated. No deficiencies related to the allegations are cited.

Survey dates: April 7, 8, 2014

Facility number: 000032
Provider number: 155077
AIM number: 100273330

Survey team:
Connie Landman RN-TC
Megan Burgess RN

Census bed type:
SNF: 13
SNF/NF: 96
Total: 109

Census payor type:
Medicare: 14
Medicaid: 93
Other: 2
Total: 109

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING _____ B. WING _____	C 04/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	**45 BEACHWAY DR INDIANAPOLIS, IN 46224**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Sample: 8 Lakeview Manor was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00144640, IN00144651, IN00145599, and IN00145852. Quality Review 04/09/14 by Lisa McColly	F 000		